

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/04/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>155764</b>		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>03/02/2011</b>	
NAME OF PROVIDER OR SUPPLIER  <b>SPRING MILL HEALTH CAMPUS</b>				STREET ADDRESS, CITY, STATE, ZIP CODE <b>101 W 87TH AVE</b> <b>MERRILLVILLE, IN 46410</b>			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 000	<p><b>INITIAL COMMENTS</b></p> <p>This visit was for the investigation of complaint number IN00085250 and complaint number IN00085311.</p> <p>This visit was in conjunction to a Post Survey Revisit (PSR) to the Recertification and State Licensure Survey completed on 1/14/11.</p> <p>Complaint Number: IN00085250 unsubstantiated due to lack of evidence.</p> <p>Complaint Number: IN00085311 substantiated, no deficiencies to the allegation are cited.</p> <p>Survey Dates: March 1 and 2, 2011</p> <p>Facility Number: 010739 Provider Number: 155764 Aim Number: N/A</p> <p>Survey Team: Sheila Sizemore, RN, TC Kelly Sizemore, RN Regina Sanders, RN</p> <p>Census Bed Type: SNF: 39 Residential: 46 Total: 85</p> <p>Census Payor Type: Medicare: 33 Other: 52 Total: 85</p> <p>Sample: 6 Residential Sample: 4</p>			F 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1 Spring Mill Health Campus was found to be in compliance with 42 CFR Part 483 Subpart B and 410 IAC 16.2 in regard to the investigation of complaint numbers IN00085250 and IN00085311.  Quality review completed 3-3-11 Cathy Emswiller RN	F 000			